MDR Tracking Number: M5-04-3566-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on June 21, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The extra spinal chiropractic manipulations (98943 & 98940) denied with U from 11-05-03 through 12-31-03 and the physical testing (muscle testing 97750-MT) performed on 12-12-03 **were** medically necessary. The IRO agrees with the previous determination that all remaining services and procedures **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-21-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
10-13-03	95851 x4	$30.60 x4	$0.00	G	$30.61 x 4	Medicare Fee Schedule Rule 133.304 (c)	Carrier didn't specify which service 95851 was global to, therefore it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $122.40.
10-16-03	98940	$30.13	$0.00	G	$30.14	Medicare Fee Schedule Rule 133.304 (c)	Carrier didn't specify which service 98940 was global to. Therefore, it will be reviewed according to the Medicare Fee Schedule. Recommend

							reimbursement of $30.13.
10-16-03	97139-EU	$18.25	$0.00	F	$18.25	Medicare Fee Schedule	The requestor submitted relevant documentation to support the services billed. Recommend reimbursement of $18.25
10-16-03	99070	$50.00 ($25.00x2)	$0.00	A	DOP	Medicare Fee Schedule Rule 134.202(d)	Per Rule 134.600 only DME in excess of $500 per item require preauthorization. Therefore, 99070 will be reviewed in accordance with the Medicare Fee Schedule. The requestor submitted relevant documentation to support services billed. Recommend reimbursement of $50.00.
DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Max. Allowable Reimbursement)**	**Reference**	**Rationale**
10-16-03	99080-73	$15.00	$0.00	N	$15.00	Medicare Fee Schedule	The requestor submitted a copy of the Work Status Report (TWCC73). Therefore, recommend reimbursement of $15.00
10-16-03	97124	$25.69	$0.00	G	$25.70	Medicare Fee Schedule	Carrier didn't specify which service 97124 was global to. Therefore, it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $25.69.
10-17-03 through 11-14-03	98943 x11	$27.97	$0.00	G	$0.00	Medicare Fee Schedule	98943 was denied by the carrier with "G", unbundling. This code reports a procedure, service or supply that is not covered or valid for Medicare. Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is

							provided with any additions or exceptions in this section." Therefore, reimbursement is not recommended.
11-10-03	98940	$30.13	$0.00	G	$30.14	Medicare Fee Schedule	Carrier didn't specify which service 98940 was global to. Therefore, it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $30.13.
12-12-03	95851 x 2	$30.60 x2	$0.00	G	$30.61 X 2	Medicare Fee Schedule	Carrier didn't specify which service 95851 was global to. Therefore, it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of $61.20.
TOTAL							The requestor is entitled to reimbursement of $352.80.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 10-13-03 through 12-31-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3566-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 6, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Patient is a 35-year-old male roofer who, on ___, fell from the edging of the roof and landed onto the ground feet first. He felt immediate pain in both ankles, his hip, and his right wrist, along with headaches and neck pain. He was treated initially in the ER, then received surgery on 07/15/03 to his right ankle and wrist. He then received post-operative physical therapy 2 times per week for 3 weeks to reportedly only his right ankle with no specific therapy rendered to his right wrist. He then obtained a change of treating doctors to a doctor of chiropractic, and began physical therapy and rehabilitation under their care on 10/06/03.

REQUESTED SERVICE(S)

Massage therapy (97124), group therapeutic exercises, 2 or more patients (97150), therapeutic exercises (97110), office visits, minimal (9921-25), office visits, problem-focused (99212-25), office visits, expanded problem-focused (99213-25), motorized traction (97012), chiropractic manipulative therapy, spinal (98940), chiropractic manipulative therapy, extra-spinal (98943), simultaneous electrical stimulation/ultrasound (97139-EU), adhesive electrodes (99070), diathermy (97024), physical testing (97750-MT), and range of motion testing (95851) for dates of service 10/16/03 through 12/31/03, but *excluding* items marked as "fee" within the range.

DECISION

The extra spinal chiropractic manipulations (98943 and 98940 are approved and the physical testing (muscle testing 97750-MT) performed on 12/12/03 is approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

In this case, the documentation supported a compensable injury to the patient's right wrist, right ankle, and – to a much lesser extent – his cervical and lumbar spines. Therefore, the performance of chiropractic manipulative therapy to these areas during this time frame in dispute was determined to be medically necessary. Further, as it is appropriate to perform periodic reevaluations to determine the patient's status and response to care, the medical necessity of the physical evaluation (97750-MT muscle testing) performed on 12/12/03 was supported.

However, a review of the explanation of benefits (EOBs) reveal that each office within the stated time frame reported 8 units of therapeutic exercises (97110) having been performed, 6 of which were already reimbursed by the carrier through 12/01/03, with only one unit having been reimbursed for date of service 12/5/03. Then, according to the EOBs, no additional therapeutic exercise was reimbursed after 12/5/03. Given the diagnosis and extent of injury in this case, the medical necessity of only 6 units is supported through 12/01/03. After this date, continued supervised therapeutic exercise was not medically necessary, as the patient could easily have been transitioned to a home program. Further, with this amount of supervised therapeutic exercise being performed on every encounter, the medical necessity of an additional group therapeutic exercise therapy session (97150) was not supported because this would have been duplicative.

Moreover, Section 413.011, Labor Code, provides that the TWCC must use the reimbursement policies and guidelines promulgated by the Medicare system. The "Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuires" Reimbursement Policies applicable to the Texas Medicare system provide as follows: "It is expected that patients undergoing rehabilitative therapy for musculoskeletal injuries in the absence of neurological compromise will transition to self-directed physical therapy within two months…Only the more refractory cases requiring additional therapy are expected to continue beyond this point and additional documentation of necessity and medical certification by the supervising physician is required." In this case, the treating doctor has exceeded the recommended two months of active care established by the Medicare Reimbursement Policies. Since no documentation was submitted establishing either (a) objective proof of neurological compromise; or (b) that this is a refractory case, the medical necessity of the treatment cannot be supported. This rendered not only the additional therapeutic exercise medically unnecessary, but also the massage therapy (97124), the simultaneous electrical stimulation/ultrasound therapy (97139-EU), the adhesive electrodes that were dispensed (99070), and the mechanical traction therapy (97012) medically unnecessary.

Insofar as the office visits (99211-25, 99212-25 and 99213-25) and the range of motion tests (95851) were concerned, these were all

components of either the pre-, mid- and post-manipulative treatments already reported in 98940 or 98943, or – in the case of the range of motion testing (95851) – it was a component of 97750-MT, all performed on the same dates of service. Therefore, repeating these procedures on the same date would be duplicative and as such, not medically necessary.